

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008431

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2304

STATE FILE NUMBER

FILED MAR 14 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN	
St. Louis		One day		East St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)	
John Cochran V.A.		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		409 Illinois Ave.	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last			Month Day Year		
Harry Cashion			Feb. 26 1963		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR
Male	White		4-4-1896	66	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Laborer		Construction		Rockwood, Ill.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Cyrus Cashion		Alice Thayer		unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>				Mrs. Ruby Causson Rockwood, Illinois	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cerebral Edema. Subarachnoid Hemorrhage.					
Contributing causes, coronary Sclerosis.					
Chronic Hypertension. apparently suffered in					
last down stairs at home. exact time and date					
DUE TO (b) DUE TO (c) <del>could not be determined</del>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
accident 900-0 21					
PART III. If deceased was female was there a pregnancy in last 90 days.					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
				See above	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
				7E Home	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
East St. Louis, Illinois					
21. I attended the deceased from _____ to _____ and last saw her him alive on _____ Death occurred at _____ 8:25 P. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
Helen L. Taylor, Coroner		1300 Clark Ave.		2-28-63	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-2-63		Spring Vale	
23d. LOCATION (City, town, or county)		23e. DATE RECD. BY LOCAL REG.		23f. REGISTRAR'S SIGNATURE	
Road Dist. #2 Randolph Co.		11. FEB 28 1963		Road Smith, M.D.	
24. FUNERAL DIRECTOR ADDRESS					
Schroeder Funeral Home Chester, Ill.					

USE BLACK INK

OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James J. Cresson*

Licensed Embalmer No. 5168

P. O. Address Millstadt, Illinois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.